TESTIMONY OF CHARLES C. MADDOX, ESQ.

INSPECTOR GENERAL

BEFORE THE COMMITTEE ON THE JUDICIARY

INSPECTION OF THE OFFICE OF THE CHIEF MEDICAL EXAMINER

SEPTEMBER 25, 2003

GOOD MORNING CHAIRPERSON PATTERSON AND MEMBERS OF THE COMMITTEE. I WELCOME THIS OPPORTUNITY TO SHARE WITH YOU THE RESULTS OF OUR INSPECTION OF THE OFFICE OF THE CHIEF MEDICAL EXAMINER, HEREAFTER REFERRED TO AS OCME. AT THE TABLE WITH ME TODAY ARE AL WRIGHT, ASSISTANT IG FOR INSPECTIONS AND EVALUATIONS, AND LAWRENCE PERRY AND VAUGHN CAUTHEN, SENIOR INSPECTORS FOR THE OCME INSPECTION. THIS TESTIMONY WILL PROVIDE BACKGROUND ON THE CONDUCT OF THIS INSPECTION AND HIGHLIGHT THE MOST CRITICAL FINDINGS AND ISSUES FACING THE OCME.

BACKGROUND AND OBJECTIVES

OCME'S MISSION IS TO INVESTIGATE AND CERTIFY ALL VIOLENT DEATHS, ALL DEATHS THAT OCCUR UNEXPECTEDLY, ALL DEATHS THAT OCCUR IN THE ABSENCE OF MEDICAL ATTENTION OR IN POLICE CUSTODY, AND ALL DEATHS THAT POSE A THREAT TO PUBLIC HEALTH. THE INSPECTION FOCUSED ON THE MANAGEMENT AND OPERATIONS OF KEY AREAS, INCLUDING:

- MORTUARY AND AUTOPSY SERVICES;
- FORENSIC INVESTIGATIONS;
- RECORD KEEPING;
- CASE MANAGEMENT;
- LABORATORY SERVICES;
- PERSONNEL; AND
- OVERSIGHT OF THE DISTRICT'S CHILD FATALITY REVIEW COMMITTEE.

IN ADDITION, AT CHAIRPERSON PATTERSON'S REQUEST, WE UNDERTOOK A REVIEW OF ALLEGATIONS REGARDING OCME'S HANDLING OF AN AUTOPSY CONNECTED TO THE SNIPER SHOOTINGS IN OCTOBER 2002. I WILL ADDRESS OUR FINDINGS CONCERNING THIS ISSUE AS WELL.

HOW THE INSPECTION WAS CONDUCTED

THE INSPECTION TEAM (TEAM) REVIEWED BEST PRACTICES RECOMMENDED BY THE NATIONAL ASSOCIATION OF MEDICAL EXAMINERS (NAME), CONDUCTED 54 INTERVIEWS, ISSUED AN ANONYMOUS AND CONFIDENTIAL EMPLOYEE SURVEY, OBSERVED ALL OCME WORK AREAS AND KEY WORK PROCESSES, REVIEWED NUMEROUS DOCUMENTS, AND VISITED MEDICAL EXAMINERS OFFICES IN SURROUNDING JURISDICTIONS TO DETERMINE BEST PRACTICES.

I AM PLEASED TO SAY THAT BOTH OCME MANAGEMENT AND EMPLOYEES WERE FULLY COOPERATIVE AND RESPONSIVE DURING ALL PHASES OF THE INSPECTION. IN ADDITION, THEY CONCURRED WITH THE MAJORITY OF OUR FINDINGS AND RECOMMENDATIONS. WHERE THEY DID NOT CONCUR, THEY PROVIDED ACCEPTABLE ALTERNATIVES AND CLEARLY ARTICULATED THEIR INTENT TO TAKE APPROPRIATE CORRECTIVE ACTION.

SPECIAL REPORT ON OCME HANDLING OF SNIPER VICTIM'S AUTOPSY

INCLUDED IN OUR REPORT OF INSPECTION AT APPENDIX 11 IS AN OIG SPECIAL REPORT ENTITLED *HOW OCME HANDLED THE AUTOPSY OF SNIPER VICTIM PASCAL CHARLOT*. THIS SPECIAL REPORT WAS PREPARED IN RESPONSE TO CHAIRPERSON PATTERSON'S REQUEST THAT THE OIG INVESTIGATE ALLEGATIONS THAT "ACTIONS BY CHIEF MEDICAL EXAMINER DR. JONATHAN ARDEN SERVED TO DELAY FOR 12 TO 16 HOURS THE DETERMINATION THAT MR. PASCAL CHARLOT (CHARLOT) WAS A VICTIM OF THE WASHINGTON-AREA SNIPER WHEN HE WAS SHOT TO DEATH ON OCTOBER 3, 2002."

WE COULD NOT CONCLUDE THAT DR. ARDEN CREATED AN UNNECESSARY DELAY IN THE CHARLOT AUTOPSY. HOWEVER, WE DO RECOMMEND IN OUR REPORT THAT OCME ADDRESS THE NEED TO PROVIDE AFTER-HOURS AUTOPSY CAPABILITY TO ASSIST MPD OR OTHER INVESTIGATIVE AGENCIES DURING TIME-SENSITIVE, UNUSUAL INVESTIGATIVE SITUATIONS, AND OTHER SPECIAL CIRCUMSTANCES.

A QUESTION WAS ALSO RAISED BY MS. PATTERSON AS TO WHETHER PERCEIVED DIFFERENCES BETWEEN DR. ARDEN'S TESTIMONY BEFORE THE JUDICIARY COMMITTEE ON APRIL 10, 2003, AND HIS STATEMENTS TO OCME STAFF REGARDING THE WEAPON USED TO SHOOT CHARLOT CONSTITUTED AN ATTEMPT TO PROVIDE INACCURATE OR MISLEADING INFORMATION TO THE COMMITTEE.

WE COULD NOT CONCLUDE THAT DR.ARDEN PROVIDED INACCURATE INFORMATION OR INTENDED TO MISLEAD CHAIRPERSON PATTERSON WHILE PROVIDING TESTIMONY. WE DO NOTE THAT IT WOULD HAVE BEEN PRUDENT IF, DURING HIS TESTIMONY, DR. ARDEN HAD DELINEATED FOR THE COMMITTEE THE STEPS THAT WERE TAKEN BY HIM AND HIS STAFF AT THAT TIME, IN A MORE COMPREHENSIVE MANNER, IN ORDER TO AVOID THE MISUNDERSTANDING AND CONFUSION THAT ENSUED.

HIGHLIGHTS OF MAJOR INSPECTION FINDINGS

AS STATED EARLIER, THE INSPECTION TEAM FOUND SIGNIFICANT DEFICIENCIES IN NEARLY ALL INSPECTED AREAS OF OCME. THE FOLLOWING, HOWEVER, ARE WHAT I CONSIDER TO BE THE MAJOR FINDINGS IN THE REPORT:

LONG-STANDING PROBLEMS CONTINUE UNDER THE CURRENT CME. OUR PRIMARY MESSAGE TODAY IS THAT ALTHOUGH THE INSPECTION TEAM FOUND OCME EMPLOYEES TO BE DEDICATED AND ENTHUSIASTIC ABOUT THE MISSION

OF THE OFFICE AND THE ROLES THEY PLAY, EMPLOYEES NEVERTHELESS ARE DEEPLY TROUBLED ABOUT DEFICIENCIES IN MANAGEMENT POLICIES AND PRACTICES THEY BELIEVE ARE HARMFUL TO THE WELL-BEING OF BOTH EMPLOYEES AND OFFICE OPERATIONS. THE TEAM FOUND THAT THE SAME PROBLEMS REPORTED IN AN INDEPENDENT STUDY AND BY THE LOCAL MEDIA FROM 1998 TO 2001 STILL EXIST TODAY. OPERATIONAL DEFICIENCIES, AUTOPSY BACKLOGS, A LACK OF BASIC POLICIES AND PROCEDURES, PERSONNEL PROBLEMS, AND LOW MORALE REMAIN UNRESOLVED SINCE THE CURRENT CHIEF MEDICAL EXAMINER, WHOM I WILL REFER TO HEREAFTER AS THE CME, ASSUMED OFFICE IN 1998. IN LIGHT OF THE INCREASED RESOURCES MADE AVAILABLE TO OCME OVER THE PAST 5 YEARS, AND THE SIGNIFICANT SUPPORT FROM BOTH THE MAYOR AND THE CITY COUNCIL, THE TEAM ATTRIBUTES THE POOR PERFORMANCE OF THIS AGENCY TO MANAGEMENT FAILURES IN THE OFFICE OF THE CME.

EMPLOYEES AT EACH LEVEL OF OCME VOICED SPECIFIC COMPLAINTS ABOUT THEIR INDIVIDUAL TREATMENT BY THE CME AND, IN SOME CASES, NOTED THAT THEY HAD CONSULTED WITH ATTORNEYS AS WELL AS DISTRICT AND FEDERAL EEO OFFICIALS BECAUSE OF ALLEGED IMPROPER OR UNFAIR PERSONNEL ACTIONS. THE TEAM ALSO INTERVIEWED FORMER EMPLOYEES WHO MADE UNSOLICITED VISITS TO OIG TO VOICE THEIR COMPLAINTS AND CONCERNS. THE OIG IMMEDIATELY REFERRED BOTH CURRENT AND FORMER EMPLOYEES TO THE D.C. OFFICE OF HUMAN RIGHTS WHEN THEY RAISED ALLEGATIONS OF HARASSMENT AND DISCRIMINATION.

OCME HAS NOT BEEN INSPECTED AND ACCREDITED AS HAVE MEDICAL EXAMINERS' OFFICES IN SURROUNDING JURISDICTIONS, WHICH MEANS OCME RECEIVES NO OBJECTIVE PROFESSIONAL EVALUATIONS. OCME OPERATES WITHOUT AN EXTERNAL, OBJECTIVE PEER REVIEW OF ITS OPERATIONS. THE NATIONAL ASSOCIATION OF MEDICAL EXAMINERS, WHICH I WILL REFER TO HEREAFTER AS NAME, RECOMMENDS THAT MEDICAL

EXAMINERS OFFICES BE INSPECTED AND ACCREDITED BY AN EXTERNAL ENTITY. NAME FURTHER RECOMMENDS THAT THIS ACCREDITATION BE CONDUCTED BY THE MEDICAL EXAMINERS' PEERS AND PROVIDE A REALISTIC ASSESSMENT OF THE QUALITY OF THE FACILITY AND RECOMMENDATIONS FOR IMPROVEMENT. ACCREDITATION ALSO PROVIDES REASONABLE ASSURANCE THAT A MEDICAL EXAMINER'S OFFICE MEETS ESTABLISHED STANDARDS AND PROCEDURES AND IS CAPABLE OF PROVIDING THE REQUIRED SERVICES. THE TEAM FOUND THAT THE MEDICAL EXAMINERS' OFFICES IN THE SURROUNDING JURISDICTIONS OF MARYLAND, VIRGINIA, AND PENNSYLVANIA ARE ACCREDITED BY NAME. JURISDICTIONS IN WHICH OCME OFFICES ARE NOT ACCREDITED BY NAME TYPICALLY ARE OVERSEEN BY OTHER SPECIALIZED ENTITIES ABLE TO OBJECTIVELY EVALUATE AND ACCESS OCME OPERATIONS. THE DISTRICT, HOWEVER, HAS NO REGULATIONS REQUIRING INSPECTION, ACCREDITATION, OR EVALUATION OF OCME BY ANY DISTRICT GOVERNMENT AGENCY OR EXTERNAL ORGANIZATION. WITHOUT AN INTERNAL OR EXTERNAL OBJECTIVE PEER REVIEW OF ITS OPERATIONS, DISTRICT STAKEHOLDERS CANNOT BE ASSURED THAT OCME MEETS ESTABLISHED NATIONAL STANDARDS AND PROVIDES RECOGNIZED LEVELS OF QUALITY SERVICE TO DISTRICT CITIZENS.

OCME HAS A SIGNIFICANT BACKLOG OF UNWRITTEN, PENDING AUTOPSY REPORTS. A COMPLETED DEATH CERTIFICATE FOR A DECEDENT WHO MUST UNDERGO AN AUTOPSY CANNOT BE ISSUED UNTIL AN AUTOPSY REPORT HAS BEEN PRODUCED. ALTHOUGH AN INCOMPLETE CERTIFICATE (ONE THAT DOES NOT STATE THE CAUSE AND MANNER OF DEATH) CAN BE USED FOR BURIALS, NEXT OF KIN MUST HAVE A COMPLETED CERTIFICATE IN ORDER TO CLAIM INSURANCE BENEFITS, OBTAIN GOVERNMENT BENEFITS, SETTLE AN ESTATE, OR INTITIATE LEGAL ACTION. BEST PRACTICES SHOW THAT AUTOPSY REPORTS SHOULD BE PRODUCED PROMPTLY SO THAT COMPLETED DEATH CERTIFICATES CAN BE GENERATED AND PROVIDED TO NEXT OF KIN WITH MINIMAL DELAY.

NAME RECOMMENDS THAT 95% OF AUTOPSY REPORTS BE COMPLETED WITHIN 2 MONTHS FROM THE TIME OF THE AUTOPSY IN HOMICIDE CASES, AND 95% OF REPORTS WITHIN 3 MONTHS FROM THE TIME OF THE AUTOPSY IN ALL OTHER CASES. THE DISTRICT'S OCME IS NOT MEETING EITHER OF THESE GOALS.

IN JANUARY OF THIS YEAR, THE TEAM'S REVIEW OF CASELOADS ASSIGNED TO TWO OF THE OCME MEDICAL EXAMINERS SHOWED THAT 33% OF THEIR FY 2001 CASES WERE STILL PENDING, AND 43% OF THEIR FY 2002 CASES WERE STILL PENDING. OCME MEDICAL EXAMINERS ATTRIBUTED THEIR BACKLOGS TO STAFF SHORTAGES, EXCESSIVE CASELOADS, INADEQUATE ADMINISTRATIVE SUPPORT AND THE NON-STANDARD OPERATING PROCEDURES DIRECTED BY THE CME.

OCME IS STORING UNIDENTIFIED AND UNCLAIMED BODIES, SOME DATING BACK TO 2000. THIS CREATES A HEALTH HAZARD IN THE OCME FACILITY. DISTRICT REGULATIONS REQUIRE THAT BODIES WHICH ARE UNIDENTIFIED OR UNCLAIMED AFTER 30 DAYS BE CREMATED OR OTHERWISE DISPOSED OF ACCORDING TO LAW. THE TEAM FOUND THAT OF THE 189 BODIES STORED AT OCME AS OF DECEMBER 29, 2002, 60 HAD BEEN STORED FOR LONGER THAN 30 DAYS FOLLOWING THEIR ARRIVAL IN OCME.

EMPLOYEES INDICATED THAT THESE BODIES ARE NOT BEING REMOVED BECAUSE OCME IS NOT PROCESSING PUBLIC DISPOSITION CASES (UNCLAIMED OR UNIDENTIFIED BODIES) IN A TIMELY MANNER. ALSO, THE PROCUREMENT PROCESS FOR SOLICITATION OF CONTRACTS FOR THE TRANSFER OF THESE BODIES DELAYS THE DISPOSAL PROCESS BECAUSE OCME MUST SOLICIT BIDS FROM CONTRACTORS FOR REMOVAL THROUGH THE COMPETITIVE BID PROCESS.

THE TEAM FOUND THAT OCME HAS STORAGE CAPACITY FOR 120 BODIES. AT THE TIME OF THE INSPECTION, OCME HAD NOT RELEASED OR DISPOSED OF BODIES IN A TIMELY MANNER, AND THE STORAGE ROOM WAS OVERCROWDED AND UNSANITARY. MANY BODIES WERE DOUBLE STACKED IN RACKS, AND

SOME HAD BEEN PLACED ON THE FLOOR.

I WANT TO INCLUDE FOR THE RECORD ADDITIONAL INFORMATION REGARDING THIS FINDING THAT WAS INADVERTENTLY OMITTED ON PAGE 30 OF OUR REPORT. THE TEAM FOUND THAT THE BALTIMORE, MARYLAND AND FAIRFAX, VIRGINIA MEDICAL EXAMINER OFFICES DO NOT RETAIN EITHER IDENTIFIED OR UNIDENTIFIED BODIES FOR EXTENDED PERIODS UNDER NORMAL CIRCUMSTANCES. THE BALTIMORE OCME ADMINISTRATOR STATED THAT BY LAW, THE OCME DISPOSES OF ALL BODIES AFTER 72 HOURS, EXCEPT IN CASES WHERE THERE ARE FAMILY ISSUES THAT MAY REQUIRE DELAYED DISPOSITION. SIMILARLY, THE FAIRFAX OCME ADMINISTRATOR STATED THAT THEY MAY RETAIN IDENTIFIED BODIES FROM 30 DAYS TO 6 WEEKS WHEN THERE ARE FAMILY CONSIDERATIONS THAT REQUIRE SUCH RETENTION BUT, NORMALLY, ALL BODIES ARE DISPOSED OF WITHIN A SHORT PERIOD OF TIME. AT THE TIME OF THEIR VISITS, THE OIG INSPECTORS SAW ONLY ONE IDENTIFIED BODY AWAITING DISPOSITION, AND NO UNIDENTIFIED BODIES IN STORAGE AT EITHER NEIGHBORING FACILITY.

POLICIES AND PROCEDURES FOR CONDUCTING AUTOPSIES ARE INADEQUATE. THE TEAM REQUESTED A COPY OF OCME AUTOPSY PROCEDURES IN NOVEMBER 2002, BUT WAS TOLD BY THE CME THERE WERE NONE IN WRITING AT THAT TIME. IN FEBRUARY 2003, THE CME PROVIDED WRITTEN PROCEDURES TO THE TEAM; HOWEVER, OCME MEDICAL EXAMINERS CONSIDERED THEM TO BE DEFICIENT FOR THE FOLLOWING REASONS: THEY LACKED IMPORTANT CRITERIA; THEY WERE WRITTEN BY THE CME WITHOUT THEIR INPUT, EVEN THOUGH THEY PERFORM MOST OCME AUTOPSIES, AND SOME CONTRADICTED THE CME'S VERBAL INSTRUCTIONS. THE TEAM WAS ALSO TOLD THAT OCME LACKS A CONSISTENT VERBAL OR WRITTEN POLICY FOR HANDLING REQUESTS FOR SPECIAL AUTOPSY PROCEDURES BASED ON A FAMILY'S RELIGIOUS PREFERENCES. IN ADDITION, OCME DOES NOT HAVE WRITTEN POLICIES AND PROCEDURES COVERING THE RETENTION OF ORGAN AND TISSUE SPECIMENS

STORED IN THE AUTOPSY SUITE.

THE HISTOLOGY LABORATORY WAS NOT PROPERLY VENTED, AND WASTE CHEMICALS WERE IMPROPERLY STORED AND DISPOSED OF. NAME RECOMMENDS THAT EACH HISTOLOGY WORKSTATION BE PROPERLY VENTED TO REMOVE SOLVENTS AND FUMES, AND THAT THERE BE SEPARATE STORAGE SPACE FOR WASTE CHEMICALS. AT THE TIME OF THE INSPECTION, THE TEAM FOUND THAT THE OCME HISTOLOGY LABORATORY WAS NOT PROPERLY VENTED, AND THERE WAS NO STORAGE SPACE FOR WASTE CHEMICALS. GALLONS OF USED TOXIC CHEMICALS REMAINED IN THE LABORATORY FOR WEEKS BEFORE EMPLOYEES TOOK THEM TO THE OCME LOADING DOCK TO BE PICKED UP FOR DISPOSAL.

THE TEAM FOUND THAT DESPITE THESE PROBLEMS, THE HISTOLOGY LABORATORY WAS NOT INCLUDED IN THE RECENT GENERAL RENOVATIONS OF OCME. FUMIGATION HOODS HAD NOT BEEN ORDERED FOR THE LABORATORY, AND THE TEAM FOUND STRONG CHEMICAL ODORS THAT MADE BREATHING HAZARDOUS FOR EMPLOYEES.

THE IG ISSUED A MANAGEMENT ALERT REPORT (MAR 03-I-003), DATED JANUARY 31, 2003, RECOMMENDING THAT THE DISTRICT OF COLUMBIA OFFICE OF OCCUPATIONAL SAFETY AND HEALTH (D.C. OSH) DETERMINE WHETHER THERE ARE ANY HAZARDS TO EMPLOYEES AND VISITORS AT OCME. THE HISTOLOGY LABORATORY WAS CLOSED ON JUNE 5, 2003, BY THE D.C. OFFICE OF RISK MANAGEMENT AFTER ENVIRONMENTAL TESTING CONFIRMED LEVELS OF VOLATILE ORGANIC COMPOUNDS THAT SIGNIFICANTLY EXCEEDED THOSE CONSIDERED IMMEDIATELY DANGEROUS TO LIFE AND HEALTH.

THE CME'S RELATIONSHIP WITH THE CHILD FATALITY REVIEW COMMITTEE HAS BEEN MARRED BY PROBLEMS. THE CHILD FATALITY

REVIEW COMMITTEE (CFRC), OF WHICH THE CME IS A MEMBER, WAS ESTABLISHED BY THE MAYOR AND IS RESPONSIBLE FOR EXAMINING PAST EVENTS AND CIRCUMSTANCES SURROUNDING CHILD DEATHS IN THE DISTRICT. THIS IS AN EFFORT TO REDUCE THE NUMBER OF PREVENTABLE CHILD DEATHS, ESPECIALLY THOSE ATTRIBUTABLE TO CHILD ABUSE, NEGLECT, AND OTHER FORMS OF MISTREATMENT. THE CME IS RESPONSIBLE FOR PROVIDING FACILITIES AND OTHER ADMINISTRATIVE SUPPORT FOR THE CFRC, AND IS EXPECTED TO ATTEND ALL CFRC REVIEWS OF CHILD DEATHS. THE TEAM FOUND THAT THE CME HAD NOT PROVIDED ADEQUATE ADMINISTRATIVE SUPPORT TO THE CFRC, AND DID NOT REGULARLY ATTEND CFRC MEETINGS. SOME CFRC MEMBERS BELIEVE THE ADMINISTRATIVE SUPPORT FUNCTION SHOULD BE MOVED TO A NEUTRAL LOCATION, AND NOT BE OVERSEEN BY A CFRC MEMBER, SUCH AS THE CME.

OCME STAFFING FOR SOME OF THE MOST CRITICAL AREAS IS NOT ADEQUATE. MEDICAL EXAMINER OFFICES ARE 24-HOUR A DAY OPERATIONS; THEREFORE, IT IS IMPERATIVE THAT THEY BE ADEQUATELY STAFFED TO CARRY OUT ALL KEY FUNCTIONS. ALTHOUGH OCME WAS BUDGETED FOR 65 FULL TIME POSITIONS FOR FY 2002, THE CME DID NOT FILL 17 (26%) OF HIS BUDGETED ALLOTMENT IN A TIMELY MANNER. MANY OF THESE POSITIONS REMAINED VACANT FOR A YEAR OR MORE. THE TEAM FOUND THAT THERE IS NO MEDICAL-LEGAL INVESTIGATOR AVAILABLE ON A 24-HOUR BASIS TO RESPOND TO DEATH SCENE INVESTIGATIONS, THE NUMBER OF EMPLOYEES AVAILABLE FOR BODY HANDLING AND TRANSPORT IS INSUFFICIENT, THE COMMUNICATION UNIT 24-HOUR PHONE IS NOT ADEQUATELY STAFFED, AND OCME DID NOT HAVE ADEQUATE STAFF FOR BUILDING MAINTENANCE. THESE STAFF SHORTAGES RESULT IN EMPLOYEES HAVING TO COVER MULTIPLE SHIFTS AND WORK OVERTIME, AND MANY EMPLOYEES SAY THEY ARE ON THE VERGE OF BURNOUT.

THE CME HAS NOT PRODUCED STATISTICAL DATA AND ANNUAL REPORTS ON DEATHS AND AUTOPSIES IN THE DISTRICT OF COLUMBIA. THE D.C. CODE REQUIRES THE CME TO PREPARE AN ANNUAL REPORT TO THE MAYOR WHICH INCLUDES INFORMATION ON THE NUMBER OF AUTOPSIES PERFORMED, STATISTICS AS TO THE CAUSES OF DEATH, AND ANY OTHER RELEVANT INFORMATION THE MAYOR MAY REQUIRE. THE TEAM FOUND THAT THE CME HAS NOT PRODUCED AN ANNUAL REPORT AS REQUIRED SINCE HE ASSUMED HIS OFFICE ALMOST 5 YEARS AGO; IN FACT, HE DOES NOT APPEAR TO BE CAPABLE OF PRODUCING SUCH A REPORT BECAUSE OF INADEQUACIES IN THE OCME RECORDS SYSTEM. OCME RECORDS ARE MADE UP PRIMARILY OF HARD COPY FILES AND DOCUMENTS—SOME OF WHICH ARE HANDWRITTEN—THAT ARE NOT WELL ORGANIZED AND MAINTAINED, EVEN THOUGH THERE APPEARS TO BE SUFFICIENT STAFFING IN THIS PARTICULAR AREA. IMPLEMENTATION OF A FULLY OPERATIONAL AUTOMATED RECORDS MANAGEMENT SYSTEM IS BEHIND SCHEDULE. THE LACK OF AUTOMATION MADE IT DIFFICULT FOR THE INSPECTION TEAM TO GATHER CONCRETE STATISTICAL INFORMATION ON OCME CASES AND BACKLOGS, AND ALMOST CERTAINLY INHIBITS THE CME'S RETRIEVAL OF SUCH INFORMATION FOR INCLUSION IN AN ANNUAL REPORT TO THE MAYOR.

SOME MPD OFFICERS IMPEDE DEATH SCENE INVESTIGATIONS. OCME MEDICAL-LEGAL INVESTIGATORS (INVESTIGATORS) TOLD INSPECTORS THAT DEATH SCENES OFTEN ARE DISTURBED BY METROPOLITAN POLICE DEPARTMENT (MPD) OFFICERS PRIOR TO THEIR ARRIVAL, IN VIOLATION OF THE D.C. CODE. THEY ALSO COMPLAINED THAT SOME MPD OFFICERS DELAY THE OFFICIAL PRONOUNCEMENT OF DEATH BY NOT PROMPTLY NOTIFYING OCME OF ALL DEATHS SUBJECT TO INVESTIGATION. THE IG PROVIDED A COPY OF THIS FINDING TO MPD CHIEF OF POLICE CHARLES RAMSEY. IN HIS RESPONSE TO OUR OFFICE, CHIEF RAMSEY PROVIDED AN APRIL 20, 2003, MEMORANDUM FROM THE CME TO MPD AUTHORIZING MPD DETECTIVES TO DISTURB THE BODY FOR THEIR

OWN INVESTIGATIVE PURPOSES WHEN NO OCME INVESTIGATOR WILL BE RESPONDING TO THE DEATH SCENE, BUT WITH STRICT LIMITATIONS. DESPITE MPD'S APPARENT VIEW THAT THE CME'S MEMORANDUM RESOLVES THE ISSUE, WE BELIEVE THE CME'S MEMORANDUM AND MPD'S INTERPRETATION OF IT LEAVE AMBIGUITIES REGARDING WHAT MPD CAN OR CANNOT DO AT DEATH SCENE INVESTIGATIONS. THE CHIEF ALSO DENIED THE ALLEGATIONS OF DELAYS IN NOTIFYING OCME ON ALL DEATH CASES, INCLUDING HOMICIDES. HE STATED THAT, ON SEVERAL DOCUMENTED OCCASIONS, MPD MADE TIMELY NOTIFICATION TO OCME INVESTIGATORS; HOWEVER, OCME INVESTIGATORS DID NOT ARRIVE AT THE DEATH SCENE FOR 3 TO 4 HOURS AFTER BEING NOTIFIED.

OIG RECOMMENDATIONS

IN LIGHT OF THESE FINDINGS, WE MADE 74 SPECIFIC RECOMMENDATIONS THAT WE BELIEVE CAN ASSIST OCME MANAGEMENT IN TAKING CORRECTIVE ACTIONS, TO INCLUDE:

- IMPLEMENTING WRITTEN POLICIES AND STANDARD OPERATING PROCEDURES FOR THE MOST CRITICAL OPERATIONAL AREAS (PARTICULARLY THOSE AFFECTING EMPLOYEE HEALTH AND SAFETY) IN ORDER TO BRING CONSISTENCY, EFFICIENCY, AND SAFE PRACTICES TO THE WAY EMPLOYEES CONDUCT DAY-TO-DAY BUSINESS.

- COLLABORATING WITH THE CME'S TEAM OF MEDICAL EXAMINERS TO REVIEW THE SUFFIENCY OF POLICIES AND PROCEDURES PERTAINING TO AUTOPSIES AND OTHER OCME OPERATIONS AS PERTINENT, AND GIVING FULL CONSIDERATION TO THEIR INPUT.

- ESTABLISHING WRITTEN, STANDARD CRITERIA FOR SPECIAL AUTOPSY PROCEDURES BASED ON A FAMILY'S RELIGION, AND DEVELOPING A POLICY AND PROCEDURE FOR RETAINING AND

DISPOSING OF ORGAN AND TISSUE SPECIMENS.

- REQUIRING THAT OCME TAKE THE NECESSARY STEPS TO BE INSPECTED AND ACCREDITED BY THE NATIONAL ASSOCIATION OF MEDICAL EXAMINERS.
- INCREASING THE NUMBER OF MEDICAL EXAMINERS TO REDUCE THE BACKLOG OF AUTOPSY REPORTS, AND GIVING CONSIDERATION TO THE CONCERNS AND SUGGESTIONS OF THE MEDICAL EXAMINERS REGARDING REDUCTION OF THE BACKLOG.
- INITIATING STEPS TO ELIMINATE THE BACKLOG OF UNCLAIMED AND UNIDENTIFIED BODIES IMMEDIATELY, IN ORDER TO COMPLY WITH DISTRICT REGULATIONS.
- ORDERING AND INSTALLING FUMIGATION HOODS IN THE HISTOLOGY LABORATORY AND ESTABLISHING POLICIES AND PROCEDURES FOR THE STORAGE AND DISPOSAL OF WASTE CHEMICALS IN THE LAB.
- REQUESTING A MAYORAL REVIEW OF THE APPROPRIATENESS OF THE CME'S OVERSIGHT OF THE CFRC'S ADMINISTRATIVE SUPPORT STAFF FUNCTION AND CONSIDERATION OF A MORE INDEPENDENT OVERSIGHT LOCATION.
- ENSURING THAT OCME IS ADEQUATELY STAFFED TO CARRY OUT ALL KEY FUNCTIONS.
- IMPLEMENTING A LESSONS LEARNED APPROACH TO THE INFORMATION PROVIDED IN OUR REPORT OF INSPECTION, PARTICULARLY INFORMATION IN THE EMPLOYEE SURVEY AND EMPLOYEE COMMENTS, AND MAKING ADJUSTMENTS TO MANAGEMENT STYLE AND OPERATIONAL OVERSIGHT IN ORDER TO IMPROVE BOTH THE PERCEPTION AND THE REALITY OF A DISTRICT

AGENCY THAT IS PERFORMING POORLY.

- PROVIDING THE MAYOR WITH AN ANNUAL REPORT AS REQUIRED BY THE D.C. CODE.

- THE DEPUTY MAYOR FOR PUBLIC SAFETY AND JUSTICE CONDUCTING A REVIEW OF THIS AND PREVIOUS REPORTS ON OCME TO ASSIST THE CME IN DEVELOPING BOTH NEAR- AND LONG-TERM PLANS, AND SPECIFIC GOALS TO IMPROVE ALL OCME OPERATIONS.

- THE CME COLLABORATING WITH THE CHIEF OF POLICE ON CLARIFYING, IN WRITING, THE RESPONSIBILITIES OF OCME AND MPD PERSONEL AT DEATH SCENES, INCLUDING FINGERPRINTING OF BODIES, AND PUTTING INTO PLACE OVERSIGHT PROCEDURES THAT WILL ENSURE THAT THE INTEGRITY OF DEATH SCENES IS MAINTAINED.

- THE CME COLLABORATING WITH THE CHIEF OF POLICE TO ENSURE THAT OCME IS PROMPTLY NOTIFIED OF ALL DEATHS SUBJECT TO INVESTIGATIONS AS REQUIRED BY THE D.C. CODE.

COMPLIANCE AND FOLLOW-UP

I WOULD LIKE TO MAKE CLEAR MY BELIEF THAT AGENCY MANAGERS MUST WORK TO IMPLEMENT RECOMMENDATIONS THEY THEMSELVES ACKNOWLEDGE CAN HELP RECTIFY PROBLEMS. MY RESPONSIBILITY AS INSPECTOR GENERAL IS TO FOLLOW-UP ON THEIR ACTIONS OR THEIR INACTION, AND TO INFORM THE MAYOR, THIS COUNCIL, AND OTHER STAKEHOLDERS ABOUT AGENCY PROGRESS IN ADDRESSING THE CRITICAL ISSUES RAISED DURING OUR INSPECTIONS AND AUDITS. OUR INSPECTION PROCESS INCLUDES CONTINUOUS POST-INSPECTION CONTACT WITH INSPECTED AGENCIES TO MONITOR THEIR PROGRESS IN COMPLYING WITH OUR REPORT RECOMMENDATIONS. FOR EXAMPLE, A

COMPLIANCE TRACKING FORM FOR EACH FINDING AND RECOMMENDATION WILL BE SENT TO THE CME, AND OUR INSPECTIONS DIVISION WILL COORDINATE WITH OCME ON VERIFYING COMPLIANCE WITH OUR RECOMMENDATIONS OVER AN ESTABLISHED TIME PERIOD. WE WILL ISSUE PERIODIC REPORTS ON COMPLIANCE BY OCME AND OTHER INSPECTED AGENCIES TO THIS COMMITTEE AND TO ALL OTHER RECIPIENTS OF OUR ORIGINAL INSPECTION REPORT. BASED ON THE COOPERATION AND RESPONSIVENESS EXHIBITED THUS FAR, I AM CONFIDENT THAT OCME WILL TAKE POSITIVE STEPS TOWARD IMPROVING ITS OPERATIONS AND PERFORMANCE.

THIS CONCLUDES MY TESTIMONY ON OUR INSPECTION OF THE OFFICE OF THE CHIEF MEDICAL EXAMINER, AND I WILL BE HAPPY TO ANSWER QUESTIONS YOU MAY HAVE.